PATIENT AND STAFF ATTITUDES TOWARD CLOTHING RESTRICTIONS ON A PEDIATRIC PSYCHIATRIC UNIT

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PATIENT AND STAFF ATTITUDES TOWARD CLOTHING RESTRICTIONS ON A PEDIATRIC PSYCHIATRIC UNIT

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ABSTRACT

Pediatric psychiatric inpatients are among the most vulnerable individuals in society. While the use of seclusion and restraint is well chronicled in the field of research in this population, there are limited literature describing the effects, meaning, and attitudes of mandating the wear of clothing in hospital settings. This research explores the phenomenon of the practice of mandatory wear of hospital-issued clothing and its meaning to patients and the awareness and attitudes of this practice among staff caring for this population. This research aims to improve understanding of the experiences of patients regarding this practice at a large, urban hospital providing care for children using a mixed-methods design. A qualitative, descriptive phenomenological analysis was conducted through individual interviews with adolescent patients ($N = 5$) on an inpatient psychiatric unit. Additionally, a cross-sectional self-reported questionnaire examined the awareness and attitudes toward this practice among unit staff ($N = 41$). The patients' attitudes toward clothing restrictions were predominantly negative, noting a lack of self-expression, feeling like a mental health patient, desires to wear ones' personal clothing, impact on identity, and feelings of shame and punishment. Among the staff there was a modest correlation between age, number of years practicing as a health professional, and years practicing in a pediatric setting with feelings of a need for a change in the clothing policy to allow patients to wear their clothing on admission. Staff age and number of years working at the

institution demonstrated a modest correlation between awareness of legal statutes regarding patients' rights to their clothing. This research found a readiness among staff to adopt a clothing policy that would permit patients to wear their clothing on admission, which would improve the negative experiences described among the patients in the sample.

Keywords: child and adolescent psychiatry, patient rights, personal clothing, psychiatric hospitalization

DEDICATION

This scholarly work is dedicated to my wife, Julia, who has not only provided encouragement throughout the entirety of my academic endeavors, but who has also made countless sacrifices to support my ambitions. For this, I am eternally grateful.

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Chapter I

Introduction

Ethical issues surrounding practices in inpatient psychiatric settings are not a novel or emerging concept. Whether it is the use of restraints or involuntary hospitalization, ethical issues are replete within the framework of caring for mental health patients worldwide. Many practices in this setting are intended to maintain the safety of individuals with mental illness, but they also have the potential to serve as a source of unintended harm. Contemporary models of care delivery describe unavoidable injuries that are common to the care of hospitalized patients where the benefits of the intervention outweigh the risks of harm and require the consent of the individual. In the setting of inpatient psychiatry, the precedent that balances risks, benefits, and consent is often violated. As Goffman noted, tongue-in-cheek, "if a suicidal inmate is to be kept alive, the staff may feel it necessary to keep him…tied to a chair in a small locked room" (1961, p. 77). As a society, we have expressed a noble bearing toward maintaining the safety of individuals. When a person is at imminent risk of harm to oneself or others, legal and ethical obligations mandate that first responders and healthcare providers intervene to preserve life and safety. In this sense, the use of restraints and involuntary hospitalizations maintain ethical integrity *provided* the interventions improve safety and reduce the risk for harm. Furthermore, the practices of confinement and locked units were commonplace historically, and this is a trend that continues today in the name of patient safety. However, the culture of risk management may impact the quality of psychiatric care, and specifically, mental health nursing practice (Slemon, Jenkins, & Bungay, 2017). The line between safety and a possible violation of an individual's rights is often poorly delineated.

Restricting an individual's right to wear their clothing on an inpatient psychiatric unit is another example of an observed clinical practice that has unclear utility in providing a framework for recovery. This occurs in inpatient psychiatric settings across the lifespan, but this paper will focus on this practice in pediatric, inpatient mental health settings. There are no studies that specifically examine patient perceptions of meaning concerning this practice. Furthermore, there are no studies that examine the attitudes of unit staff regarding personal clothing restrictions.

Problem Description and Significance

Mental health problems in the United States among the pediatric population are pervasive, where approximately 21% of adolescents experience a severe mental disorder at some point during their life (Merikangas et al., 2010). Furthermore, "the consequence of untreated mental health illness in children and adolescents can be devastating for patients and their families… [where] more adolescents die by suicide than all other natural causes combined" (Krishna, Shapiro, & Houston, 2016, p. 1). Among pediatric patients with acute mental health needs, the prevalence of hospital admissions and associated costs of hospitalizations to address primary psychiatric problems are increasing; nearly 1 in 10 admissions in pediatric settings have a primary psychiatric diagnosis. This incidence exceeds the estimates of admissions due to asthma, and the financial burden in the United States for admissions from depression is comparable to the charges from admissions due to asthma (Bardach et al., 2014). A study conducted by Blader (2011) examined the prevalence of psychiatric hospitalization rates, which revealed that between 1996 and 2007, the hospitalizations for mental health concerns for adolescents increased by nearly 42%. The number of adolescents treated in the hospital and the costs associated with these admissions are on the rise, and practices serving to produce both

positive and negative hospital experiences may influence help-seeking behaviors. A systematic review by Gulliver, Griffiths, and Christensen (2010) found that the number one facilitator for help-seeking behavior was a past positive experience, and the relationship was stronger among young people.

Hospitals worldwide restrict the wear of personal clothing and instead have a policy that mandates the wear of hospital-issued scrubs (HIS). The literature is sparse in defining the incidence or prevalence of the practice of restricting personal clothing (RPC) for all patients on admission across hospitals nationwide. There are not studies that describe how these practices quantitatively impact the dignity or legal rights of patients. Not all hospitals treating children for psychiatric issues have mandated personal clothing restrictions for all admitted patients. Boston Children's Hospital affords and markets the wear of personal clothing on their inpatient psychiatric unit (DeMaso & Ryan, 2016). Similarly, Children's of Alabama's patient and parent bill of rights describes the rights of patients to wear appropriate personal clothing provided the clothing does not impede treatment (Children's of Alabama, 2018). Milliken (2016, p. 12) describes that at Nationwide Children's Hospital, in Columbus, OH, "an initiative to increase patient safety…utilizes a milieu environment that provides a structured, therapeutic group setting to help patients work through their psychiatric issues, and "in order to support this type of environment, patients wear their personal clothing." These children's hospitals create a treatment environment that is less restrictive than hospitals that mandate HIS, where reduced restrictions have demonstrated "a greater level of involvement of patients in care due to their increased level of responsibility and ability to make decisions" (Wynaden et al., 2001, p. 844).

It is imperative that psychiatric units treating adolescents tailor the environment to one of healing and positive patient experiences, yet the research on how to accomplish this is lacking

(Delaney, 2018). The quality of care in the setting of the experience and satisfaction of patients and their families are now measured to inform consumers, insurers, and health care administrators with the purpose of improving patient experience. The Child Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) metrics include items regarding patient and parent satisfaction (CAHPS Child Hospital Survey [CAHPS], 2018). One composite measure surveys the degree to which a hospital experience helped a child feel comfortable (CAHPS, 2018). Furthermore, the overall rating of a hospitalization and the degree to which a hospital is recommended are included on the CAHPS.

Legal statutes. The nurse caring for a patient on a psychiatric unit is bound by legal and ethical doctrine to advocate for patients and promote dignity and the rights of the patient, to whom their primary responsibility lies. Federal law directs all states to include laws for the provision of care and protection for patients being treated for mental illness. The 2016 Colorado Revised Statutes for the *Care and Treatment of Persons with Mental Illness* (CO Rev Stat § 27-65-101, 2016) affords an amalgamation of protections for those with mental illness, along with a framework that guides what professionals treating those with mental illness are legally obligated to do.

In the setting of patients with mental illness receiving treatment in a hospital, patients should be treated under the conditions that support a person's liberty and restrict such liberty only when this is consistent with a person's treatment needs (42 U.S.C. § 9501, 1980). Colorado law includes provisions for the wear of personal clothing, with limitations to the wear of personal clothing only if the individual being treated is at imminent risk of harm to self or others *and* other less-restrictive means are not feasible (CO Rev Stat § 27-65-101, 2016).

In the state of Colorado, the law requires that the rationale for restricting a patient's rights be documented at least every seven days, and that there is a therapeutic necessity for such restrictions (CO Rev Stat § 27-65-101, 2016, 105.1A). This includes the right of an individual to wear his or her own clothes (CO Rev Stat § 27-65-101, 2016, 105.1A). These restrictions are to be made on a case-by-case basis and for good cause when no alternative, less restrictive means are available, and it is found to be clinically necessary to preserve one's safety or the safety of others. CO Rev Stat § 27-65-101 (2016) decrees that care is "humanely administered with full respect for the person's dignity and personal integrity" and "provide the fullest possible measure of privacy [and] dignity… in the least restrictive setting" (CO Rev Stat § 27-65-101, 2016, section I) to those treated for psychiatric problems.

Additionally, Colorado law mandates the facilitation of the recovery and resiliency of individuals treated for mental health issues (CO Rev Stat § 27-65-101, 2016, section I). As described by Farkas, "whether or not a particular intervention is considered to be a rehabilitation intervention, therefore, is not defined by the simple fact that it focuses on skills or supports for individuals with serious mental illnesses" (2003, p. 162). Thus, the utility of an intervention should be based on "its contribution to the primary outcome of enhanced functioning in a valued role *and the* congruence of the value base of the intervention itself" (Farkas, 2003, p. 162). Using the definition of ethics by Velasquez et al. (2009), the standards of behavior that inform what an individual or institution ought to do may be incongruent with the commonly accepted practices at institutions providing inpatient psychiatric care, and specifically, the restriction of an individual's clothing in the setting of inpatient psychiatry, including settings that exclusively treat youth. Nevertheless, the practice of removing access to an individual's personal clothing in both pediatric and adult inpatient psychiatric settings remains a common practice.

The mandated wear of HIS does not have evidence supporting this common practice, may impact the dignity of patients and delay or worsen recovery, and may be incongruent with legal statutes. This practice provides an impetus for the evaluation of this phenomenon.

Organizational Needs Assessment

At the site of this study, a unit policy exists which states that all patients are admitted to the unit with the restriction of personal clothing. Patients remain in hospital-issued scrubs until their provider writes an order to allow for the wear of personal clothing. The length of time that patients wear hospital-issued scrubs and have their personal clothing restricted varies, and often occurs for days prior to being allowed to wear their clothing. The clothing policy is tied into the level of safety precautions, where patients with 1:1 (one staff member assigned to one patient) or line-of-sight safety precautions have their personal clothing restricted. The written justification for the policy mandating hospital-issued clothing is based on the patient being assessed as imminent risk of harming themselves and cannot have access to personal clothing because of its potential use for self-harm.

The policy has the intention of maintaining the safety of youth admitted to the unit; however, this is applied universally to all patients on admission. The implementation of the decision to restrict personal clothing and a lack of measurement of outcomes from this policy may not be congruent with the rights and protections afforded to patients. Psychiatric inpatients should wear their clothing whenever possible to preserve the integrity of treatment in the least restrictive setting and to enable recovery. As unit rules at the study site currently exist, all patients are admitted from the emergency department or transferred from the medical unit with a standing order mandating the wear of hospital clothing. However, the purpose of unit rules should aim to promote recovery and comply with legal statutes. There is not a clear

understanding of how this policy was developed and implemented, but unfavorable policies often exist and may go unnoticed in organizations due to long-established cultural norms (Schein, 2010). However, cultural norms are not always ethically well informed, and thus ethical decision making should not be influenced based on culturally normative behavior (Velasquez et al., 2009).

There are considerations for the appropriateness of clothing restrictions and mandating the wear of HIS. For example, HIS may assist staff in identifying patients on a psychiatric unit, which is of vital importance for patients determined to be a flight risk. However, the current policy on clothing restrictions at the study site does not appear to account for the possibility that the HIS may just as easily be used to impose self-harm compared to personal clothing items. Of course, personal clothing items such as a belt or a necklace are not appropriate for use or wear on a psychiatric unit. Other options for less restrictive practices are possible. For example, such a practice could include allowing the wear of personal clothing while restricting belts. Furthermore, a policy that would determine the need for the restriction of the wearing of personal clothing on a case-by-case basis is better aligned with current Colorado legal statutes in the setting of a limited evidence base to guide this clinical practice.

Population, Exposure, and Outcome Framework

The dual purpose of this Doctor of Nursing Practice (DNP) scholarly project was to: (a) explore the meaning of personal clothing restrictions throughout a hospitalization for adolescent psychiatric inpatients; and (b) examine the awareness and attitudes of staff at a large, urban inpatient adolescent psychiatric unit in Colorado.

Population and problem. For this research, the two populations of focus were: (a) adolescents of both sexes and all ethnicities (ages 14-17) admitted to the inpatient psychiatric unit at the project site, and (b) all staff that work on the inpatient psychiatric unit.

Exposure. The exposure in this study are adolescents hospitalized on the inpatient psychiatric unit at the study site who are required to wear HIS.

Outcomes. Outcomes or themes in qualitative research provide an understanding of meaning for a population of study. The qualitative interests in this study are adolescents subject to the restriction of the wear of personal clothing during their hospitalization on the inpatient psychiatric unit at the study site, and the meaning and experience of such a restriction among this population.

The outcomes from the quantitative component of the study are the awareness of and attitudes toward the study site's current clothing policy among unit staff, and the examination of differences of awareness and attitudes between differing roles and responsibilities of staff, and sociodemographic variables.

By synthesizing the components of the PEO question, this scholarly question aims to explore the meaning as well as the perception of restricting personal clothing among hospitalized youth. Specifically: (a) What is the meaning of personal clothing restrictions throughout a hospitalization for adolescent psychiatric inpatients at a large, urban inpatient psychiatric unit?; and (b) do sociodemographic variables impact the attitudes of staff regarding patient personal clothing restrictions on a pediatric inpatient psychiatric unit?

Theoretical Framework

The theoretical framework and conceptual model that was utilized to guide this scholarly project is the Compassionate Connected Care Model. The Compassionate Connected Care Model provides a framework to organize actions health care providers take into the clinical, operational, behavioral, and cultural aspects of patient care (Press Ganey, 2014).

The model aims to alleviate the suffering of individuals in healthcare settings by improving quality, bolstering culture, and increase caring behaviors. This is model is relevant to the research question in a variety of ways. First, clinical excellence is an essential framework in evaluating the safety outcomes among individuals on an inpatient unit. Second, this model enables appraisal of the match between an institution's stated culture (e.g., mission, values, and vision) and the actual culture. The model helps to clarify the disparity between the stated and actual culture in the practice of clothing restriction at the study site. Naturally, caring behaviors may be examined to assess practices and their impact on the individuals of study. Lastly, and in the context of the previously defined items, efficiency and quality may be impacted by the current practice of restricting the wear of personal clothing among adolescents admitted to the inpatient psychiatric unit at the study site.

Additionally, this model highlights that "connecting with patients in compassionate ways to alleviate inherent patient suffering and prevent avoidable suffering is key to improving the patient experience" (Dempsey, Wojciechowski, McConville, & Drain, 2014, p. 517); through this, connection with patients is enhanced, and patient care experiences are mutually improved (Dempsey et al., 2014).

The study of the Compassionate Connected Care Model (Press Ganey, 2014) demonstrates that the desire for delivering compassionate care is by itself not enough to impact healthcare outcomes. Instead, through the use of structured changes to clinical care delivery that enable providers to deliver compassionate care, outcomes may be notably improved (Tierney, Seers, Tutton, & Reeve, 2017).

Definition of Terms

This section defines the operational and conceptual variables key to the study. *Patients* in the scholarly project are defined as individuals admitted to the adolescent milieu on the inpatient psychiatric unit, and exclude individuals admitted to the child milieu. There is not a defined age that delineates whether a patient is admitted to either the child or adolescent milieu on the inpatient unit, however, the attending provider responsible for the care of the patient makes a determination at the time of admission as to which population would best match the individuals developmental age. *Clothing restrictions* are defined as mandatory wearing of hospital-issued maroon scrubs, and a restriction of the wear of personal clothing on the inpatient psychiatric unit.

Staff are defined as employees of the project site who have responsibilities in providing direct patient care on the inpatient child and adolescent psychiatric unit. Staff may include: (a) *providers,* defined as nurse practitioners or physicians; (b) *mental health counselors* (MHC), who provide direct patient care through planning, implementing, evaluating and monitoring treatment activities and groups*;* (c) *Behavioral Health Clinicians* (BHC), who are licensed clinical social workers or licensed professional counselors who develop and implement treatment and safety plans, provide individual and family therapy, and discharge planning; (d) *registered nurses* (RN); and (e) *other,* which may include clinical pharmacists, dieticians, or residents.

Chapter II

Review of the Literature

This literature review examined the evidence of the restriction of wear of personal clothing among adolescents being treated on an inpatient psychiatric setting. The literature highlights the indignity to which psychiatric patients are often subjected, including the restriction of wear of personal clothing during a psychiatric hospitalization. Nevertheless, the evidence is scarce not only to the pediatric but also the adult settings. The search strategy, while aimed at identifying articles regarding clothing policies on inpatient psychiatric units, also included articles that identify patient or provider experience and meaning surrounding the restriction of patients' personal clothing.

The limitations to the current evidence include sparse evidence about the meaning of restriction of personal clothing among both adult and pediatric inpatient psychiatric populations. As Ward (2014) noted, while there is active research in the field of recovery as it pertains to patients with medical conditions such as cancer and asthma, there is little in the way of qualitative research exploring recovery in adolescent mental health. Furthermore, there may be a lack of generalizability among the studies reviewed given the settings in which they were studied. More studies and studies of better quality are needed to determine the meaning of having the restriction of personal clothing among hospitalized adolescent psychiatric patients.

Search Criteria

A literature review was conducted using Boolean search techniques and manual review in the MEDLINE (Ovid), PsycINFO, MEDLINE (PubMed), and Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases to access research papers using Dahlgren

Memorial Library's database collection at Georgetown University. In the PubMed MEDLINE database the Boolean operator "AND" was used to combine searches using the terms cloth* (to capture "clothes" and "clothing"), psych*, and the terms inpatient and institutional* were combined with the Boolean operator "OR," which resulted in 24 articles. Articles were reviewed for inclusion and exclusion criteria. Inclusion criteria were articles published in the English language for the period 2008-2018, and applying these parameters limited the results to 8 articles. The articles were reviewed for relevance to the clinical question, and articles were included if they were in a psychiatric setting or provided historical context. Articles that were excluded from this review included articles that did not pertain to a psychiatric inpatient setting and articles that did not provide a historical background to the POE question. In applying these additional parameters, a total of three articles were included in the review: A randomized cross-over study by Delmas et al. (2017), a qualitative study by Lakeman (2011), and a historical article by Wynter (2011).

The three articles were examined using the "similar articles" feature in PubMed MEDLINE, with the same inclusion and exclusion criteria parameters applied to each search. Using the "similar articles" feature for the articles by Delmas et al. (2017) and Wynter (2011), 49 articles and 38 articles resulted, respectively yet upon applying inclusion and exclusion criteria, no additional articles were found. Applied to the study by Lakeman (2011), 28 articles were found, and upon applying inclusion and exclusion criteria, seven other studies were found including qualitative studies by Jackson, Tudway, Giles, and Smith (2009), Cleary, Hunt, and Walter (2010), Walsh and Boyle (2009); Kogstad (2009); a practice-change project by Fitzgerald (2017); a quantitative study by McDonald, Dounaevskaia, and Lee (2014); an editorial by Peate (2018). In summary, 10 total articles were gathered from the PubMed database.

The same search terms were applied to the search using the Ovid MEDLINE database, which resulted in 43 studies, and was reduced to 16 studies after excluding articles not published in the English language before 2008. After applying the additional inclusion and exclusion criteria, two studies remained, both of which were duplicate studies found in the PubMed Search.

Using the same search terms and parameters from the aforementioned databases, the PsychInfo database resulted in 40 total studies and 12 studies that were published in the English language between 2008 and 2018. After applying the inclusion and exclusion criteria, no unique studies were identified, although two studies from either Ovid or PubMed were found from this database.

In the CINAHL database 28 articles were found, and after applying the parameters for studies published in the English language between 2008 and 2018, 15 total articles were found, with one unique article—a double-blind peer-reviewed article by Woods, Bond, and Helen (2017)—and two duplicate articles from the previously searched databases were found.

Broadening an understanding of meaning is integral for effective qualitative research. To this end, a preliminary literature search in EMBASE and PubMed MEDLINE databases was conducted to expand the scope of the meaning of clothing among adolescents regarding identity formation, self-concept, acculturation. A secondary manual search was also performed. In the PubMed MEDLINE database, the Boolean operator "AND" was used to combine searches using the terms cloth* and adolescen*, which resulted in seven articles after applying inclusion criteria that included articles published in the English language for the period 2005-2018. The same Boolean search technique and inclusion criteria were used to a search in the EMBASE database, which resulted in three unique articles and two duplicate articles found in the PubMed MEDLINE database search. Duplicate articles were excluded.

Critique and Synthesis of Previous Evidence

The overall grading of the evidence was moderate using LEGEND (Let Evidence Guide Every New Decision) criteria (Cincinnati Children's Hospital Medical Center, 2012). The evidence includes a single well-done trial and multiple large, high-quality qualitative studies; however, multiple low-quality studies were also identified.

There is little in the literature defining the incidence or prevalence of the practice of restricting personal clothing for all patients on admission across hospitals nationwide, or how these practices quantitatively impact the dignity or legal rights of patients. Most of the existing evidence is reflected in qualitative studies, with few quantitative studies in the literature.

While the literature demonstrates ample evidence of the indignity felt by individuals with restrictions of personal clothing, no articles were found during the search process that either addressed or measured safety and how it pertains to the restriction of personal clothing on an inpatient psychiatric unit. Furthermore, all of the literature reviewed regarding restriction of clothing and patient safety only describes the experiences of individuals treated on an adult psychiatric setting, and no articles focused specifically on the child or adolescent population setting. The experiences of patients subjected to clothing restrictions provide a background for the need for exploration of this research topic.

Impact of Clothing Restrictions on Inpatient Mental Health Units

Qualitative studies add patient meaning to restrictions of clothing. One study explored the salient social identity of mental health inpatient service users via utilization of semi-structured interviews, with aims to determine what groups do these individuals identify with, how these individuals perceive others outside of this group of individuals (for example staff and non-psychiatric service users), and how these individuals view their uniqueness in comparison to

others (Jackson, Tudway, Giles, & Smith, 2009). This study found that the most salient social identities were mental health groups to include both staff and inpatients, however identification was not constant and depended on "factors specific to mental health [patients], such as phase of inpatient stay, psychological well-being, mood, and self-protection from institutionalization and other inpatients" (Jackson et al., 2009, p. 175). Qualitative research using semi-structured interviews conducted by Kogstad (2009) investigated the dignity and violations thereof considered from psychiatric patients' perspectives. The findings concluded that respecting the dignity and integrity of psychiatric patients is seen as the means to recovery, and that "infringements that cannot be explained without reference to their status as clients in a system which, based on judgments from medical experts, has a legitimate right to ignore clients' voices as well as their fundamental human rights" (Kogstad, 2009, p. 383). The narratives could be grouped into three main categories: 1) experienced miscommunication, 2) rejection, and 3) humiliation and punishment. Furthermore, this study "verifies an existence of a gap between human rights' aims and clients' experiences in several settings" (Kogstad, 2009, p. 390).

The process of receiving mental health care and how it is delivered has an impact on identity development in an adolescent. Ward (2014) describes how the period of adolescence and the experiences therein provides the framework for, and influence of, adult identity formation. Moreover, expert opinion by Lakeman (2011) aimed to explore the meaning of requiring hospitalized psychiatric patients to wear pajamas (scrubs) and what the persistence of this practice and other practices might mean. Lakeman (2011) found that many of these practices are incompatible with the recovery process, having no evidence to support their effectiveness, including requiring hospitalized psychiatric patients to wear pajamas (scrubs), persists worldwide in psychiatric inpatient treatment. Regarding the routine use of hospital scrubs on

admission to inpatient psychiatric units is an antiquated practice for which little evidence exists to suggest that it improves desired health outcomes. In fact, this practice is a "potential source of distress and conflict and relegates the person to the position of the child relative to others" (Lakeman, 2011, p. 481).

Impact of inpatient unit policy on patients. There is no clear evidence to suggest that the practice of mandating the wear of HIS improves patient safety, while there is evidence suggesting that this practice may affect an individual's dignity. Slemon et al. (2017) describe that on inpatient psychiatric units, indignity occurs through a process where a patient's autonomy is replaced with behaviors dictated by the institution; patients are not only under continuous observation but are also subject to adopting a diminished range of behavior and expression deemed to show normalcy. Those not adopting the socially-constructed acceptable behaviors are subject to "punitive measures as removal of personal clothing privileges, seclusion in isolation rooms and physical restraint" (p. 2). Such indignities, including the restriction of wear of personal clothing, are often institutionally authorized (Ernst, 2016) and rationalized under the auspices of safety. Importantly, it is often unclear if such measures afford improved safety or rehabilitative outcomes for the patient (Sailas & Wahlbeck, 2005), and may do more harm than good. These institutionally sanctioned rationalizations that restrict autonomy may be reframed as necessities, and by virtue of reframing the "interventions as necessities, at its extreme, permits the development of inhumane treatment", in which "freedom of action, including movement in the outside world, is reframed as a privilege which reinscribes the notion that individuals with mental illness are dangerous; both incapable of looking after themselves and a threat to the community, and legitimizes the development and maintenance of unethical practices" (Slemon et al., 2017, p. 2). Furthermore, research from Khan, Daw, and Hampson (2011) found that

restrictions on clothing are frequently excessive and unnecessary security measures, where "restrictions on a patient's autonomy compromise their dignity and rights as an individual" (p. 13). Safety and risk policies should serve to hasten recovery, yet clothing restrictions can interrupt recovery and worsen mental illness (Khan et al., 2011).

A prospective, randomized, cross-over study performed in a single unit comparing presentation in pajamas to presentation in day clothes and the impression of severity of depression on an inpatient psychiatric unit found that the patients wearing hospital-issued scrubs were significantly associated with the clinicians' perceiving a greater severity of depression among such patients (Delmas et al., 2017).

A systematic content analysis conducted by Walsh and Boyle (2009) aimed to improve understanding of psychiatric inpatients' strategies for coping with mental illness and how inpatient psychiatric hospitals are facilitative to the individual attempting to recover. The main themes of concerns identified for psychiatric inpatients were: 1) information, 2) communication, 3) relationships, 4) activities, 5) self-help, 6) patient involvement in care treatment plans, and 7) the physical environment.

One case study aimed to encourage discussion and evidenced-based research initiatives on the ethics surrounding restrictions in inpatient psychiatric settings. (Cleary, Hunt, & Walter, 2010), and described that seclusion remains a controversial treatment practice in the treatment of psychiatric inpatients and that this practice may be appropriate given adequate consideration of less-restrictive alternative interventions.

Children's hospitals that have unit policies allowing patients to wear their clothing on admission create a less restrictive treatment environment. These particular children's hospitals do not have the policies that mandate the wear of HIS to all admitted patients, and in turn create

a treatment environment that is less restrictive, which has demonstrated "a greater level of involvement of patients in care (due to their increased level of responsibility and ability to make decisions)" (Wynaden et al., 2001, p. 844).

Development of adolescent identity. The literature about clothing and its interplay with identity and self-concept demonstrated that adolescents are acutely aware of their clothing and that an individual's clothing as compared to others in the same peer group or culture has emotional ramifications. A study by Sweeney and Zionts (1989) evaluated the relationship of perceptions of disturbed and non-disturbed early adolescents on clothing, self-concept, and body image, and found that there were emotional effects regarding the use of clothing among both groups and the ability for clothing to influence mood. Furthermore, MacGillivray and Wilson (1997) investigated how adolescents used clothing. The authors identified that "significant differences were found between stages of adolescence on clothing use, satisfaction with clothing and satisfaction with appearance of the body" (MacGillivray & Wilson, 1997, p. 43).

Rationale for Project

Clothing restrictions for adolescents during inpatient psychiatric hospitalizations have an unclear utility in improving patient safety, and this practice is restrictive to patients' autonomy, may impact dignity, and hinder recovery. Patients are restricted from their personal belongings to include clothing and placed in hospital-issued scrubs to improve safety. Being in a hospital is an uncomfortable and unfamiliar setting for many, and this is exacerbated in the environment of children as patients and due to the stigma surrounding mental health treatment. The decisions to restrict clothing items seem to lack congruence with the stated values of honoring the trust of patients through generous service and boundless creativity.

There is a problem in the delivery of mental health care as it pertains to patient rights to wear personal clothing, and the literature suggests that such policies create a climate that may cause harm to patients, violating their dignity, and often failing to align with legislation. Furthermore, there is a lack of evidence to support such practices, which are primarily incongruent with nursing law and ethics; The American Nurses Association (ANA) Code of Ethics (2015) highlights ethical obligations of the nurse, including caring for patients regardless of health problems to include respect for the dignity and worth of the individual, where the nurse has a primary commitment to the patient and must advocate, promote, and protect the health, safety, and rights of the patient.

As Kuosmanen, et al. found, "51 people who had experienced deprivation of liberty in the context of psychiatric hospitalization in Finland, and confiscation of clothing and forced wearing of pajamas was associated with shock, shame, and humiliation, and was largely seen as unjustified" (2007, p. 604). Does the 'shock, shame, and humiliation' that is felt to be unwarranted and the perceived deprivation of liberty that patients experience provide any benefit from restricting clothing? Moreover, what is the meaning of restricting an adolescent's wear of personal clothing during an inpatient psychiatric hospitalization? These questions are the aims of this research. The rationale for this research project is to explore the meaning of personal clothing restrictions throughout a hospitalization for adolescent psychiatric inpatients at the study site in order to provide improved context to the patient experience.

Chapter III

Methods

Design

This DNP project was a mixed-methods study using both qualitative and quantitative designs. The qualitative design used was a cross-sectional, descriptive phenomenological analysis (DPA), where adolescents on the IPU who enrolled in the study participated in a one-time, private, semi-structured interview with the PI that lasted no more than 60 minutes. The appropriate design for the qualitative component of this research was selected based on the area of interest for this study. The goal of descriptive phenomenological research is to elicit the human experience in a particular setting (Groenewald, 2004). Thus, a descriptive phenomenological analysis study design was selected. The quantitative aspect of this study was a structured, cross-sectional design utilizing a web-based, self-reported questionnaire (SRQ) instrument given to staff at the study site to assess participants' attitudes and awareness of the current clothing policy.

Aims

The aims of this project were: (a) to understand the experience of the mandatory wearing of hospital-issued clothing and the personal clothing restriction among adolescent patients on an inpatient psychiatric unit; (b) to examine the inpatient psychiatric unit staff perception and experience of the practice of patients having to wear hospital-issued scrubs with a restriction of a patient's personal clothing; (c) to examine the staffs attitudes of the clothing policy on the inpatient psychiatric unit; and (d) to examine the relationships between the staff perceptions, experiences, and attitudes surrounding the clothing policy and the sociodemographic variables of

age, gender, level of education, specific role of staff on the inpatient unit, previous practice settings, number of years in practice, and number of years working on the specific inpatient unit of study.

Setting

For the qualitative DPA, the PI conducted the research at an 18-bed inpatient child and adolescent psychiatric unit at a large urban medical center. The PI identified and recruited potential participants directly on the inpatient unit at the study site. All research procedures were performed in a private room on the inpatient unit at the study site. For the quantitative arm of the study, there was no physical study site as the survey was web-based.

Sampling Plan

Qualitative arm. The minimum number of participants needed to complete the qualitative arm of the study was five. Screening for potential participants occurred until a minimum of five participants were enrolled with a maximum of 10 participants enrolled, at which point no further individuals would be recruited. The number of participants needed to likely develop sufficient saturation was five (Boyd, 2001).

Adolescents admitted to the inpatient unit at the study site were screened by the PI for eligibility by chart review of the electronic health record (EHR).

Inclusion criteria. Inclusion criteria for the qualitative arm of the study included: (a) current inpatients on the inpatient psychiatric unit, (b) adolescents $\geq$ 14 years of age, (c) fluency in the English language, and (d) were wearing hospital-issued scrubs.

Exclusion criteria. Exclusion criteria were: (a) patients with active psychosis or any acute or chronic condition that would limit the ability of the patient to participate in the study, (b)

pregnant women, (c) parental refusal to give consent and/or adolescent refusal to provide assent, and (d) individuals that were under the direct care of the PI.

Quantitative arm. The number of individuals screened for the quantitative arm of the study was all inpatient staff providing direct patient care, and the number expected to be enrolled was limited only by the number of staff involved in direct patient care and those staff members who elected to not consent to the study.

Inclusion criteria. Inclusion criteria for the quantitative arm of this study were: (a) staff involved in direct patient care that worked on the inpatient unit, including licensed providers (physicians or nurse practitioners), licensed behavioral health clinicians, licensed registered nurses, mental health counselors, and other staff not meeting the aforementioned defined roles; (b) staff who had access to a computer to use the Qualtrics survey platform; and (c) staff with an active employee email address.

Recruitment Methods

Qualitative arm. The PI identified potential participants through the review of the EHR for all patients currently admitted to the IPU at the study site. Abstraction from this EHR was based on the inclusion criteria and chosen via a purposive sample of the patients from the EHR. Upon identifying potential participants, the EHR was used for further data abstraction: The PI, who served as the abstractor, reviewed the EHR to confirm eligibility through the inclusion and exclusion criteria. If the case met eligibility, the PI proceeded with recruitment of a potential participant. If the patient was not eligible, the PI chose alternate patients until the desired patient sample was reached. The following data element were manually extracted for enrolled participants by the PI from the EpicCare EHR:

Age • Sex • Race • Date of Admission • Safety Precautions • Primary Diagnosis • Pregnancy Status

Female patients of child-bearing age that were admitted to the inpatient psychiatric unit typically have labs to confirm pregnancy status, which are documented in the EHR; female patients with unknown or positive pregnancy status were excluded from the study. Upon identification of potential participants, the PI met with the potential participants to provide informed consent and informed assent, reviewed the inclusion and exclusion criteria, and audio recorded the semi-structured interview with the adolescent participant. The duration of an individual participant's participation in the study was a one-time interview no longer than 60 minutes in length. The duration anticipated to enroll all study participants was eight weeks, and the estimated date for the PI to complete the study was 10/1/2019.

Quantitative arm. Potential subjects for recruitment were identified through a listserv of institutional email addresses of potential subjects who worked on the inpatient psychiatric unit. Upon identifying potential subjects, the PI sent an email to the email addresses from the listserv with an advertisement for participation in the study and a link to the survey instrument to complete the survey. Subsequent email reminders were sent at 7-day intervals for three weeks after the initial email to remind individuals to consider completing the survey. Two advertisements were used for the quantitative arm of the study: (a) the email with the link to the survey instrument had an advertisement for participating in the study; and (b) flyers were placed at the study site two weeks prior to the recruitment email being sent out and remained for four weeks after the recruitment emails were sent to potential subjects. The duration of an individual subject's participation in the study was the completion of a one-time, web-based, self-reported questionnaire that took less than 10 minutes on average to complete. The duration anticipated to

enroll all study subjects was four weeks, and the estimated date for the investigators to complete this study was 10/1/2019.

Procedures

Qualitative arm. Individuals were screened by the PI for inclusion and exclusion criteria at the study site by review of the EHR. Sociodemographic data were collected during the study including Age, Sex, Race, Ethnicity, Date of Admission, Safety Precautions, Primary Diagnosis, and Pregnancy Status; this data was obtained by extraction from the EHR by the PI. Potential participants and their parent(s) were informed of the purpose, procedures, and alternatives to participation in the potential participant's private room during family visiting hours. Parents were asked to sign the consent form and participants were read an assent form and asked to sign the assent form. Participants who met inclusion/exclusion criteria and agreed to participate in the study were interviewed the same day they provided assent. The PI escorted participants to a private room at the study site where the interview was conducted. The qualitative interview was performed by the PI, who is a board-certified psychiatric-mental heath nurse practitioner and was able to make determinations as to whether the participants should continue in the study. All participants ($N = 5$) completed the study. Upon arrival to the interview area, the participant was debriefed regarding the purpose of the interview and given an additional opportunity to agree to participate in the study and ask any additional questions they may have had. The PI then began audio-recording and facilitated the semi-structured interview. The PI asked follow-up questions based on the guiding interview questions, although these were directly related to the stated purpose of the study. Upon conclusion of the interview, the PI escorted the participant back to the milieu at the study site.

Qualitative semi-structured interview questions. The following interview questions were asked of all of the participants in the qualitative arm of the study:

- Please tell me about the experience of having your clothing taken from you and changing into hospital-issued scrubs.
- How did, or how do you experience not being allowed to wear your own clothing and wearing hospital-issued scrubs during your hospitalization?

Throughout the interview, the investigator asked follow-up questions while enabling the participant to provide depth to their experience related to the initial interview questions.

Quantitative arm. The PI screened staff for inclusion and exclusion criteria at the study site. An advertisement email was sent to potential staff subjects who met inclusion/exclusion criteria with a link to participate in the study; these emails were sent every seven days for three weeks to those who had not entered the study. Those who followed the link in the email read an implied consent statement and were informed of the purpose, procedures, and alternatives to participation. Upon review of the email and implied consent statement, subjects entered the study by moving forward with the survey and had the option to not proceed with the survey. Subjects electing to proceed completed the survey.

Quantitative self-reported questionnaire instrument. The investigator-created 25-item SRQ (Appendix A) included three primary domains: (a) sociodemographic domain, (b) perception and experience domain, and (c) attitude domain. The SRQ response items were identified through a synthesis of literature review and collaboration with four subject matter experts (SME) in the fields of psychiatry and study design. The SMEs reviewed the SRQ for content validity, and after the PI made amendments, the SRQ was again reviewed by the SMEs.

The response items were in direct relationship to the aims of the study. The survey was coded for dissemination using the Qualtrics platform.

There was a conscious effort to limit the length of the survey, given the negative correlation between survey length and response rates (Liu & Wronski, 2018). Furthermore, sending reminder emails to participants is an effective method to increase survey response rates, as revealed in a systematic review by Fan and Yan (2010), yet there is also evidence that more than three reminders may decrease overall response rates (Van Mol, 2017).

Sociodemographic domain. The sociodemographic domain included age, sex, ethnicity, race, highest level of education (Associate's, Bachelor's, Master's, or Doctoral), role on the inpatient unit (RN, Behavioral Health Clinician (BHC), Mental Health Counselor (MHC), Provider (N.P., M.D., or D.O.), or Other, and primary responsibility at the institution in which the research was conducted (inpatient, outpatient, research, or other). Additional sociodemographic data collected included the number of years practicing as a health professional, the total number of years practicing in a pediatric setting, the amount of time working on the inpatient unit at the study site, previous work experience in pediatric settings and the type of settings (inpatient, outpatient, mental health and non-mental health settings), and previous work experience on an inpatient psychiatric setting where patients were mandated to wear hospital-issued clothing (e.g., scrubs) on admission.

Perception, experience, and attitude domains. The questions in the perception, experience, and attitude domains captured staff perceptions, experiences, and attitudes surrounding the practice of patients having to wear hospital-issued scrubs and having a restriction of their personal clothing. The participants selected the level to which they agreed with statements on a sliding, visual analog scale (VAS), allowing for ratio-level data analysis.

Protection of Human Subjects

This research project received approval from the Georgetown University (GU) Institutional Review Board (IRB) and the study site IRB under an expedited review, and the study was implemented under the approved procedures for the protection of human subjects. The PI completed required training on the protection of human subjects through the Collaborative Institutional Training Initiative (CITI). The PI and the DNP project faculty advisor addressed IRB-related conditions and made amendments as requested by the IRBs, and the PI maintained relationships with the administrators and key stakeholders at the study site. External IRB coordinators from the study site confirmed that documentation from the GU IRB was complete, PI education requirements were met, and no conflict of issues were outstanding for the PI. The study site external IRB coordinators assured that the required reliance agreement was sent for signatures needed for approval to conduct the proposed study. Upon confirmation of final approval of all outstanding committees and reviews, and acknowledgment that the IRB reliance agreement was in place, the external IRB coordinator from the study site sent the PI documentation that the study was cleared to proceed by issuing an outside IRB approval, where the GU IRB served as the IRB of record. The inpatient unit and department administrators supported this research.

Consent and assent for the qualitative arm of the study were obtained and documented in writing. The research presented no more than minimal risk of harm to subjects and involved no procedures for which written documentation of consent is normally required outside of the research context. The written script of the information was provided orally, and all written information provided included all required and appropriate additional elements of consent disclosure. The only record linking the participant and the research was the consent document.

The consent process for the quantitative arm of the study was via implied consent prior to completion of the web-based survey on Qualtrics.

Data Management and Confidentiality

All data and records generated during this study were kept confidential in accordance with institutional policies and HIPAA. The PI and other study team members used data and records only for purposes of conducting this study. The data collected was only the minimum data necessary to answer the research questions. For both arms of the study, data was stored in a secure, locked, password-protected spreadsheet on a password-protected computer with an encrypted hard drive; the computer had computer software in place to protect against malware including Symantec Endpoint Protection. All operating systems and software patches and updates were applied regularly. Email was not used to collect, store, or transmit sensitive human subject research data or Protected Health Information. Access to the data was provisioned and approved only to the study team. The datasheet used for statistical analyses included only the study numbers with de-identified information.

Steps were taken to protect participants' privacy interests. The subjects participating in the qualitative arm were only known to the PI and to staff working on the unit upon obtaining consent and assent for the study. The subjects in the quantitative arm of the study completed an anonymous questionnaire and did not need to disclose personal information or interact with any persons to complete the study.

For the qualitative component of the study, the data collected were deidentified, and both subject name and birth date were deidentified by converting these identifiers to a unique study number and age in years, respectively. The PI collected the digital audio-recorded interviews using a Sony ICDUX560BLK Digital Voice Recorder, and the interviews were immediately

transferred from the audio-recording device to a secure, locked, password-protected audio file on a password-protected computer; immediately upon transferring the audio file the PI deleted the audio recording from the audio-recording device.

For the quantitative arm of the study, the survey was anonymous, and there were no unique identifiers collected. Qualtrics online survey software was utilized to distribute the questionnaire and aggregate questionnaire data. Data from the questionnaire was downloaded as a Microsoft Excel© file and saved onto a secure GU Box platform.

Data Analysis Plan

Data analysis for the qualitative arm of the study was developed with input from the DNP project faculty advisor. The audio-recorded interviews were transcribed verbatim by the principal investigator into word processing software and uploaded to the secure Georgetown University Box cloud-based data storage service. Using Giorgi's (1985, 2005) framework for content analysis, each transcript was read by the PI in its entirety three times to gather a collective sense of the whole. Notes were then formulated to categorize the participants' portrayal of the phenomenon of interest into common patterns that were consistent with the aims of the study. The psychological insights were then articulated among the previously identified categories. The identified categories were synthesized into a general and consistent statement about the meaning of the participants' experiences. To enhance reliability, validity, and credibility to the initial analysis conducted by the PI, the project mentor—a qualitative researcher—conducted an independent content analysis and the thematic findings from the PI and the project mentor were compared.

The PI and the study statistician collaborated to generate the data analysis plan for the quantitative arm of the study. The data were shared with the statistician, and IBM SPSS statistics

software was used to conduct statistical analyses. Descriptive statistics were run to identify the frequencies, distributions, measurements of central tendency, percentages, and variability among the sample. As the perceptions, experiences, and attitudes domains included ratio-level data, multiple statistical techniques were used for analysis. To determine if there were any statistically significant differences in perceptions, experience, and attitudes toward the clothing policy among independent sociodemographic variables, a one-way ANOVA was used to explore differences among (a) education level; and (b) role on the unit. An independent samples *t-t*est was run for elicit differences between genders. Pearson product-moment tests were conducted to examine correlations between sociodemographic variables and staff perceptions, experience, and attitudes toward the clothing policy. Comments provided by study subjects were considered in the discussion section, but thematic analysis was not the aim of the study.

Budget Analysis

There were few budget requirements for the completion of this project. Statistician expenses, utilizing a GU faculty statistician at a rate of $25.00/hour, incurred a total cost of $81.25 for 3.25 hours of statistical guidance. The audio-recording device, a Sony ICDUX560BLK Digital Voice Recorder, cost $75.00. Transportation costs to and from the study site were estimated to be less than $10.00. No significant costs were incurred for materials or project tools. The total cost for the study was $166.25.

Chapter IV

Results

The results of the study included both the descriptive phenomenological analysis conducted by the PI and the project mentor, and the statistical analysis of the self-reported questionnaire, conducted by the PI in collaboration with the study statistician. Emergent themes from the interviews with the participants were identified and described. The data from the staff were analyzed using descriptive and inferential statistics. Staff comments from the questionnaire were reviewed and described.

Descriptive Phenomenological Analysis

Participants were screened using inclusion and exclusion criteria. There were a total of five participants, all of whom were female, with a mean age of 15.6 years old. Three participants were white, one multi-racial, and one African American. All participants had been assigned line-of-sight safety precautions. The participants had primary diagnoses of depression (n = 2), Post-Traumatic Stress Disorder (n = 2), and Bipolar II Disorder (n = 1). All participants were admitted to the hospital July 2019. While the allotted time for the interviews was up to 60 minutes, all five interviews lasted between 6 to 10 minutes.

Table 1. Characteristics of Qualitative Participants

Age	Sex	Race	Safety Precautions	Primary Diagnosis
17	Female	Multi-racial	Line of Sight	Major Depressive Disorder
17	Female	White	Line of Sight	Bipolar II Disorder
14	Female	White	Line of Sight	PTSD
14	Female	White	Line of Sight	PTSD
16	Female	African American	Line of Sight	Unspecified Depressive Disorder

To strengthen the confirmability of the qualitative findings, the interview tapes were reviewed by the project mentor, who has a background as a qualitative researcher, and there was agreement on the themes and findings. The most salient themes that emerged from the data were a lack of self-expression, feeling like a mental health patient, desires to wear personal clothing, identity, and feelings of shame and punishment.

Lack of self-expression. One theme that emerged from the data was the limitations of HIS in enabling patients to express themselves through the wear of uniform clothing. It was observed that participants felt that personal clothing afforded an opportunity to demonstrate one's' identity, and clothing restrictions inhibited this form of self-expression.

> "I feel like I have no, like, way to express myself, you know? People normally express themselves through how they dress, you know? Umm so, yeah, I mean it's just kind of boring, I feel boring. And like, it's hard to tell what some of the other kids are like because they're in scrubs too, like what they would wear on a normal day-to-day basis. You can't express yourself."

> "I mean, it would show a little bit more of who you are. Like, your style, like it would change the atmosphere of how people communicate and also if they want to talk to you because I know my style is more dark and edgy or whatever, so I don't know if a lot of people would want to talk to me and with you not wearing anything that represents you, you're just there."

Feeling like a mental health patient. Another theme that emerged from the data was that wearing HIS made people feel like a mental health patient. The wear of HIS reinforced the concept that patients were in a hospital for psychiatric reasons and caused a negative sense of self.

"Umm, it's just kind of weird because I look down, I just don't feel like myself, like cause I look like this I feel… kind of like a crazy person in these scrubs."

"I don't like it because my clothing is the way I express myself and how I tell people how I am feeling without verbally saying it, so it kind of makes me feel like I am not really myself. And another thing is I already know I am in a hospital, if I could have something from home to not feel so anxious, that would be better."

"You are in here for a reason, you are in a mental hospital."

Wearing personal clothing and identity. A predominant theme was that participants desired to wear their clothing. The participants expressed that wearing their clothing would enable them to feel a sense of comfort, with one participant describing that they would feel more able to receive help from their hospitalization if they were wearing their clothing. Additionally, the use of their clothing was clearly associated with identity and how they perceive themselves.

"I'd feel more comfortable here, wearing my own clothes."

"I feel more comfortable in my clothes than in hospital clothes."

"Clothing is a way to tell what kids are like."

"Clothing represents you."

"If you have your own clothes on, you might feel like more at ease, per se. More at ease for being here because you are not in some other random-ass clothes that they give you… you would feel like you are allowed to wear your own clothes, its calm, its relaxed, more able to receive the help more."

"My clothes are kind of like a safety blanket for me. I don't know why; I don't understand fully. I just know that having my clothes makes me feel like myself."

Feelings of punishment and shame. The final theme was that wearing HIS led to feelings of punishment and shame. Participants expressed a perceived negative external visibility in wearing HIS. Attitudes toward wearing HIS were those of indignity, humiliation, and inferiority.

"[Wearing scrubs] makes me feel conspicuous."

"It makes me feel weird. Slightly, just like kind of a patient."

"I hate it."

"I just hate the whole process, being stripped and handing them your clothes."

"I think it's dehumanizing." And "I feel like it's dehumanizing like in a fucking prison. But it's not even close, but you know you are not allowed to wear your own clothes until a few days, or, whatever, I don't know, I feel like it's dehumanizing, even though it's probably not supposed to be like that, that's how I see it."

"I just don't like it; it just makes you feel inferior to everyone around you."

Safety. It was unclear if clothing restrictions made the participants feel safer, with four participants suggesting that it did not improve their sense of safety but one participant suggesting that she could see benefits in a reduction of access to sharp items or ligature devices such as strings from hooded sweatshirts. "I always thought it was like for safety reasons, but then again, I don't exactly understand that either because clothes are clothes. I mean like, it's fabric. You can't really harm yourself with fabric exactly."

Staff Attitudes and Awareness

Staff demographics. The self-reported questionnaire was sent out to staff members on the unit, and 47 staff members began the questionnaire; however, six did not complete the attitudes and awareness portion of the survey, and their data were not used for data analysis. The

sample ($N = 41$) was largely female (85.4%), white (80.5%), with ages ranging from 23 to 63 years old ($M = 33.71$, $SD = 9.85$). 11 were RN (26.8%), 18 were MHC (43.9%), 3 were BHC (7.3%), 5 were providers (12.2%), and 4 were other (9.8%). Twenty had a 4-year degree (48.8%), 16 had a professional degree (39.0%), and 5 had a doctorate (12.2%). Descriptive statistics for the sample included: the number of years practicing as a health professional ($M = 9.41$, $SD = 9.05$); the number of years practicing in a pediatric setting ($M = 7.78$, $SD = 8.08$); and the number of years working at the study site ($M = 4.71$, $SD = 4.58$). In addition, 26 (63.4%) subjects previously worked in a pediatric setting prior to working at the study site, of which 17 previously worked in an inpatient psychiatric pediatric setting (65.4%), and 11 previously worked in an outpatient psychiatric pediatric setting (42.3%). Eleven subjects previously worked in an inpatient, psychiatric setting where patients were mandated to wear hospital-issued clothing on admission (26.8%), and among these subjects who worked in these settings, 3 (27.3%) were in pediatric, psychiatric settings, 2 (18.2%) were in adult psychiatric settings, and 6 (54.5%) were in both pediatric and adult psychiatric settings.

Table 2: Characteristics of Quantitative Sample ($N = 41$)

	N	***%***
Gender		
Male	6	14.6
Female	35	85.4
Race		
White	33	80.5
Black or African American	1	2.4
Asian	2	4.9
Mixed Race	2	4.9
Other	3	7.3
Ethnicity		
Non-Hispanic	34	82.9
Hispanic	7	17.1
Education		
4-Year Degree	20	48.8
Professional Degree	16	39.0
Doctorate	5	12.2

	N	*%*
Role		
RN	11	26.8
BHC	3	7.3
MHC	18	43.9
Provider	5	12.2
Other	4	9.8

Attitudes and awareness. Subjects answered the degree to which they agreed with questions about attitudes and awareness of clothing restrictions using a sliding scale ranging from 0 (*never* or *not at all*) to 100 (*always* or *absolutely*). Among the questions surveyed descriptive statistics were calculated and the mean response and standard deviation for the following questions are listed: subjects who had previously thought about the practice of patients wearing hospital-issued scrubs and having a restriction of their personal clothing (M = 67.4, SD = 25.7); clothing restrictions being brought up by patients during their inpatient hospitalization (82.8, SD = 20.5) and being brought up by family members (M = 67.4, SD = 20.4); the current clothing policy should change (M = 53.7, SD = 32.8); there are benefits to restricting a patient's clothing (M = 66.8, SD = 29.6); a change in the clothing restriction policy hinder the ability to provide quality care (M = 26.7, SD = 27.0); a policy should be implemented to allow patients to wear their clothing on admission (M = 52.4, SD = 31.9); anticipated legal problems with changing the current clothing policy to allow patients to wear their clothing on admission (M = 30.0, SD = 27.8); anticipated safety problems with changing the current clothing policy to allow patients to wear their clothing on admission (M = 57.9, SD = 29.6); pervious concerns about the current clothing policy prior to taking the survey (M = 55.5, SD = 31.4); belief that patient/family satisfaction scores would be positively impacted if patients were permitted to wear their clothing (M = 63.7, SD = 23.4); the current policy of clothing restriction upon admission should remain as

it is now (M = 49.5, SD = 32.8); awareness of the state statute regarding the wearing of personal clothing (M = 49.8, SD = 36.8).

Findings demonstrated there were no statistically significant differences in attitudes and awareness between genders using a Student's independent t-test. To examine whether there were differences in responses to the survey questions by role or education level, a one-way ANOVA was run to compare mean responses by role and education level, respectively. There were no statistically significant between-group differences among education level or role on the unit however, there were notable trends. BHC's felt most strongly that the current clothing policy should change (M = 73.5) and providers felt least likely to support a change (M = 45.1). Providers (M = 79.9) and RN's (70.4) were more inclined to express benefits to clothing restrictions than BHC's (M = 52.9) and MHC's (M = 66.4). Providers were most likely to believe that the patient/family satisfaction scores would be positively impacted if a clothing policy permitted patients to wear their clothing (M = 74.0). Providers expressed the most awareness of legal statutes regarding the wear of personal clothing (M = 71.6), and BHCs expressed the least awareness (M = 19.7).

Pearson product-moment correlations were run to determine correlations between variables of interest. There were statistically significant positive, moderate correlations with age, $r(39) = .465$, $p = .002$; years practicing in health care, $r(39) = .474$, $p = .002$; years practicing in pediatrics, $r(39) = .467$, $p = .002$; and years at the study site, $r(39) = .310$, $p = .048$; with the prompt *I feel the current clothing policy should change*. The older and more experienced staff were, the more likely they were to agree with the statement *do you think a policy should be implemented to allow patients to wear their own clothing on admission?* and was significantly

moderately correlated with age, $r(39) = .381$, $p = .014$; years practicing in health care, $r(39) = .386$, $p = .013$; and years practicing in pediatrics, $r(39) = .421$, $p = .006$.

Older and more experienced staff were less likely to see safety problems associated with changing the clothing policy. In response to the question, *do you anticipate safety problems with changing the current clothing policy to allow patients to wear their own clothing on admission?* there was a significant, moderate, negative correlation with and age, $r(39) = -.346$, $p = .027$; years practicing in health care, $r(39) = -.403$, $p = .009$; and years in practicing in pediatrics, $r(39) = -.334$, $p = .033$.

Older and more experienced staff were more likely to have had concerns with the current clothing policy, where there was a significant, moderate, positive correlation with age, $r(39) = .358$, $p = .021$; years practicing in health care, $r(39) = .442$, $p = .004$; and years practicing in pediatrics, $r(39) = .409$, $p = .008$.

The older and more experienced staff saw more positive impacts on patient and family satisfaction if patients were allowed to wear their clothing, with a significant, moderate, positive correlation with age, $r(39) = .319$, $p = .042$; years in practicing health care, $r(39) = .314$, $p = .046$; and years practicing in pediatrics, $r(39) = .339$, $p = .030$.

Older and more experienced staff were less likely to think the clothing policy should stay the same, where there was a significant, large, negative correlation with age, $r(39) = -.501$, $p = .001$; years practicing in health care, $r(39) = -.510$, $p = .001$; and years practicing in pediatrics, $r(39) = -.501$, $p = .001$. There was also a significant, moderate, negative correlation with years practicing at the study site, $r(39) = -.316$, $p = .044$.

Staff awareness of the legal statute regarding wear of personal clothing had a significant, moderate, positive correlation with age, $r(39) = .324$, $p = .039$, and years practicing at the study site, $r(39) = .369$, $p = .018$.

Table 3: Pearson correlations.

		Age	Years practicing as a health professional	Years practicing in a pediatric setting	Years worked at the study site
I have thought about the practice of patients having wearing hospital-issued scrubs and having a restriction of their personal clothing.	*r*	.225	.296	.383*	.339*
	p	.157	.060	.014	.030
	N	41	41	41	41
The practice of patients having a restriction of their personal clothing has been brought up by patients during their inpatient hospitalization.	*r*	.085	.106	.211	.090
	p	.596	.508	.185	.577
	N	41	41	41	41
The practice of patients having a restriction of their personal clothing has been brought up by family members of patients during their inpatient hospitalization.	*r*	.026	.034	.128	-.089
	p	.874	.832	.426	.579
	N	41	41	41	41
I feel that the current clothing policy should change.	*r*	.465**	.474**	.467**	.310*
	p	.002	.002	.002	.048
	N	41	41	41	41
There are benefits to restricting a patient's clothing.	*r*	-.145	-.236	-.200	.069
	p	.366	.137	.209	.668
	N	41	41	41	41
Would a change in the clothing restriction policy hinder the ability to provide quality care?	*r*	-.199	-.251	-.215	-.201
	p	.213	.113	.176	.208
	N	41	41	41	41
Do you think a policy should be implemented to allow patients to wear their own clothing on admission?	*r*	.381*	.386*	.421**	.194
	p	.014	.013	.006	.224
	N	41	41	41	41
Do you anticipate legal problems with changing the current clothing policy to allow patients to wear their own clothing on admission?	*r*	-.213	-.217	-.167	-.100
	p	.180	.173	.298	.532
	N	41	41	41	41
Do you anticipate safety problems with changing the current clothing policy to allow patients to wear their own clothing on admission?	*r*	-.346*	-.403**	-.334*	-.103
	p	.027	.009	.033	.523
	N	41	41	41	41
Have you had concerns about the current clothing policy before taking this survey?	*r*	.358*	.442**	.409**	.278
	p	.021	.004	.008	.078
	N	41	41	41	41
Do you think patient/family satisfaction scores would be positively impacted if patients were permitted to wear their own clothing?	*r*	.319*	.314*	.339*	.147
	p	.042	.046	.030	.360
	N	41	41	41	41
Do you think the current policy of clothing restriction upon admission should remain as it is now?	*r*	-.501**	-.510**	-.501**	-.316*
	p	.001	.001	.001	.044
	N	41	41	41	41
Are you aware of the Colorado statute regarding the wearing of personal clothing and patient rights surrounding this?	*r*	.324*	.277	.292	.369*
	p	.039	.079	.064	.018
	N	41	41	41	41

Note. *N* = sample size; *r* = Pearson product-moment correlation coefficient.
*$p < .05$, two-tailed. **$p < .01$, two-tailed.

There was no relationship between age, years practicing in health care, years practicing in pediatrics, or number of years practicing at the study site with the following questions or prompts: *There are benefits to restricting a patient's clothing*; *would a change in the clothing restriction policy hinder the ability to provide quality care?*; *do you anticipate legal problems*

with changing the current clothing policy to allow patients to wear their own clothing on admission?; *the practice of patients having a restriction of their personal clothing has been brought up by patients during their inpatient hospitalization*; and *the practice of patients having a restriction of their personal clothing has been brought up by family members of patients during their inpatient hospitalization*.

Staff comments. Participants were allowed to comment openly at the end of the questionnaire (see Appendix B). A total of nine subjects provided comments. Multiple subjects commented on the safety implications of allowing patients to wear their clothing. There were multiple comments suggesting that HIS enabled staff to keep patients safe, including a need for HIS if a patient is engaging in self-harming behavior or otherwise being "unsafe" in the hospital; newly admitted patients are more readily identified by HIS, which may increase staff awareness of a potential increased risk for elopement, suicide, or aggression; the difficulty of searching a patient's personal clothing for items that may be used in an unsafe manner. Additional comments included openness to changing the policy; and that providers do not remove clothing restrictions long after a patient's acute crisis is over.

Summary of Findings

In summary, results from the qualitative DPA showed themes of a lack of self-expression, the perception that wearing HIS made participants feel like mental health patients, participants' desires to wear their clothing, and feelings of shame and punishment. The quantitative SRQ demonstrated statistically significant, moderate-strong correlations between attitudes and awareness with a variety of sociodemographic variables, predominantly those of age, years practicing in health care, and years practicing in pediatrics.

Chapter V

Discussion and Conclusions

Discussion of Findings

The primary purpose of this DNP project was to understand patient and staff attitudes toward clothing restrictions on an inpatient psychiatric unit. This study used a descriptive phenomenological approach to identify the common practice in inpatient psychiatry of the mandatory wear of hospital-issued clothing and the meanings that this practice may have on adolescents who are inpatients on an adolescent psychiatric unit. Additionally, the staff on the unit completed a self-report questionnaire to develop an improved understanding of the awareness and attitudes toward this practice among unit staff.

This study found that adolescents on an inpatient psychiatric unit were not in favor of personal clothing restrictions, where there were emergent themes of humiliation, lack of self-expression, identity, and an enhanced perception of identifying as mentally ill. The predominantly negative experience toward personal clothing restrictions is an important finding, as previous studies have found that facilitating a positive experience is the primary driver of help-seeking behavior (Gulliver et al., 2010). As Delaney (2018) noted, there is a paucity of research on how inpatient psychiatric units that treat adolescents can create a milieu that cultivates healing. Previous research has identified that among psychiatric patients, respecting dignity and integrity facilitated recovery, and dignity infringements delay recovery (Khan et al., 2011; Kogstad, 2009). The findings from this study augment work from previous research and suggest that a clothing policy allowing patients to wear their clothing would create a more positive patient experience, and in turn, accelerate healing and recovery. The themes of shame

and humiliation found in this study reproduce previous findings by Kuosmanen et al. (2007), yet the latter examined clothing restrictions in an adult population. Furthermore, as adult identity is developed during adolescents (Ward, 2014), adolescents who see themselves as mentally ill, which, as this study found, is reinforced through the wear of hospital-issued clothing, may impede a healthy identity formation. As this study found that identity is tied to clothing use, the style and use of clothing may serve as a marker of who the person is and what they represent based on style. Identity formation is particularly important during adolescence, and efforts should be made to enable practices that improve self-esteem and a positive self-concept. Clothing restrictions may interrupt a patient's perception of a positive self-concept, where patients wearing hospital-issued scrubs seemed to reinforce the message of being a patient in the hospital, where they felt strange and conspicuous. Furthermore, personal clothing serves as a safety blanket and comfort to patients. This is relevant in that the health care system should strive for the creation of an environment in which patients feel a sense of comfort and safety; allowing one to wear their clothing may enable an improved sense of security. Moreover, not having one's personal clothing is one additional step that patients must go through to "earn" their right to wear their clothing. Patients may see this process as a barrier to overcome in the treatment process.

This study also found sociodemographic factors among staff that were correlated with attitudes toward allowing patients to wear their clothing. While there were no significant differences between different staff roles, gender, or race—owing to a small and relatively homogenous sample—there were multiple factors that had significant correlations with attitudes toward clothing restrictions. Staff attitudes concerned with clothing restrictions were typically correlated with age, number of years practicing as a health professional, number of years

practicing in a pediatric setting, and number of years working at the study. Staff who were older, had more years of experience as a health professional, and more experience in pediatrics were more likely to feel that the current clothing policy should change, which correlated with this demographic's negative attitudes toward the current clothing policy. Furthermore, these staff were more likely to believe that a new policy should be implemented to change the current restrictive clothing policy and allow patients to wear their clothing on admission. They also were less likely to anticipate safety problems associated with such a change. Prior to this study, it was not known how these sociodemographic factors would affect staff attitudes. It was possible that older staff, more experienced staff, or staff who had worked at the study site longer would be less open to changing the clothing policy due to the more deeply ingrained cultural norm of clothing restrictions as "the way things have always been done." The data showed that this was not the case, and it happens that the staff that are older, more experienced, and with longer time working at the study site are more likely to welcome a change to the current clothing policy.

The findings from the quantitative arm of the study may be contextualized through the lens of Benner's novice to expert theory (1982). Experience, as a competency, grows as one progresses from novice to expert. The novice lacks experience and relies on an analytical approach and an application of theory to appraise and solve problems. Meanwhile, the expert augments formal education, theory, and analytical tools with their experience. In this study, attitudes in favor of changing the clothing policy, or at least noticing problems with the policy, were correlated with professional experience.

Limitations

There were multiple limitations to this study. First, the qualitative arm of the study had an all-female sample of participants. Furthermore, the sample included only adolescents between 14 and 17 years old, which, while consistent with the sampling plan, does not allow for the generalizability of the findings to younger patients. Additionally, the research was conducted at one study site, and other factors beyond clothing restrictions may have served to influence the meaning elicited by study participants. In addition, this study did not engage in member checking with the participants after the data were analyzed to get their response to the findings. Furthermore, the interviews in this study were only conducted by the PI. Including another individual to collect data via interviews could possibly yield different results. Moreover, the PI is male, and it is possible that a female interviewer could elicit different results, as all the participants were female. While it is beyond the scope of this research to discuss whether responses would be more or less accurate given the gender of the interviewer relative to the genders in the sample, these differences have a possibility of improving credibility by adding depth and breadth to the results. The sample size ($N = 5$) provided recurrent and consistent themes, however, taking data saturation as a process as opposed to an event (Saunders et al., 2018), it is possible new insights may have emerged from further data collection. Furthermore, while 60 minutes were allotted for each interview, the average length of time of the interviews was around 10 minutes, which could impact the depth of the qualitative data.

For the quantitative arm of the study, the primary limitation was the total number of staff available to be surveyed due to the size of the staff on the inpatient unit. While there was an adequate response rate and representation of staff among the different roles on the inpatient unit, the number of participants remained too small to determine if there were between-group

differences among the types of health care staff being surveyed. Furthermore, there was a lack of diversity in the sample, where the majority of the respondents were white, female, non-Hispanic/Latino subjects. The use of a self-reported questionnaire was an appropriate choice to meet the aims of the study and aided in ease of dissemination; it would be challenging to determine staff attitudes and awareness through direct observation. Nevertheless, there are inherent disadvantages attributable to all self-reported questionnaires. This includes the potential for subjects to amplify their true answers and misunderstanding or to misinterpret the questions. Additionally, there was a potential for social desirability bias and intermediate or extreme responding to questions or prompts. There was also a potential for acquiescence bias, yet the strength of positive correlation with the prompt, *I feel that the current clothing policy should change,* was quite similar to the negative correlation with the prompt, *do you think the current policy of clothing restriction upon admission should remain as it is now?* Staff attitudes and awareness may have been elicited using qualitative methods, including either individual interviews or focus groups, which may have revealed different results.

The SRQ could have improved validation. While the PI-created SRQ instrument was developed in collaboration with content experts, the reliability and precision of the instrument were not statistically tested, as this was the first study using the instrument. Another limitation of the results from the SRQ was that the data analysis did not control for outliers or extreme responders. Finally, where the quantitative arm of the study only interviewed adolescent patients, the staff answered questions about their attitudes and awareness of the clothing policy on the inpatient unit as a whole, which treats both children and adolescents. Moreover, the questionnaire did not instruct the subjects to respond in the context of only adolescent patients.

Implications for Practice, Research, and Policy

This study appears to be the first to examine the meaning of the mandatory wear of clothing on adolescent patients and the first to examine the attitudes and awareness of staff toward such a clothing policy. This augments previous research on the psychiatric hospital environment, which describes the impact of ambient, architectural, and design features on patient and staff functioning (Karlin & Zeiss, 2006). One major implication from this study is that clothing policies allowing patients to wear their clothing may reduce the indignity felt by the patients and improve patient experience, the latter of which may increase help-seeking behavior. There is an opportunity for systems improvements, where policy endeavors across hospitals caring for adolescents on psychiatric units could align their clothing policy with the findings of this study, which encourages the wearing of personal clothing during a hospital stay.

The comments from the SRQ raised questions that provide another area for additional research. There were multiple comments regarding the perceived improvement of safety of patients wearing HIS. This included the notion that patients should wear HIS if they were unsafe on the inpatient unit. The rationale behind why the staff who commented on the SRQ felt this way was not clear, but it is possible, there was an implied improved sense of safety if patients wore HIS. As previously cited, there is no evidence wearing HIS improves safety beyond identifying individuals deemed to be a flight risk. Other comments could be perceived to suggest that using HIS clothing was a way to dissuade patients from being "unsafe," and while likely not the conscious intention of the comments, this rationale is inherently punitive. Further research exploring staff thought process behind clothing restrictions and safety might deepen the understanding of this phenomenon.

Recommendations for Nursing Practice and Further Study

This study provides an opportunity to increase awareness of clothing restrictions on inpatient psychiatric units. While this study focused on adolescent patients and staff on a child and adolescent psychiatric unit, there is an opportunity to study this phenomenon on adult psychiatric units. Furthermore, a larger qualitative sample with greater diversity may solidify support for this study's findings. Additionally, a larger, multi-site research study would add to the strength of the data and potentially allow for the evaluation of between-group differences in staff attitudes and awareness of clothing restrictions on inpatient psychiatric units. Another area of exploration includes the need to determine the prevalence of this practice in both pediatric and adult inpatient psychiatric settings. There is the potential to measure patient outcomes upon changing the clothing policy, which may measure changes to variables including length of stay, patient and family satisfaction, and number of safety incidents on the unit. There is a need for further research to explore the factors that enhance positive experiences among psychiatric patients.

It is unclear why, overall, the staff in this study were more likely to feel there are benefits to restricting clothing. While they were more likely to feel that the clothing policy should change and were less likely to feel that changing the clothing policy to allow patients to wear their clothes would impact the ability to provide quality care, they felt, albeit slightly, that such a change could create safety problems. Another interesting area for further study is to determine why there was relative neutrality to implementing a policy to allow patients to wear their clothing on admission, while at the same time feeling patient and family satisfaction might be improved with a change.

This study informs nursing practice in that the way hospitals care for their patients may not always align with what is best for the patient. The role of the nurse is to advocate for their patients, and this study found that patients have negative attitudes toward clothing restrictions. There is no evidence that the practice of clothing restrictions improves patient safety for the vast majority of patients (Lakeman, 2011), with the exception being those patients with a flight risk. Implementation of a quality improvement initiative to modify the existing clothing policy at the study site and other inpatient psychiatric units treating adolescents is recommended, followed by an evaluation of the impact.

Appendix A

Staff Clothing Attitudes and Awareness Questionnaire

Q1.1 Dear PMHI staff member,

You are invited to participate in a research study of patient and staff attitudes toward clothing restrictions on a pediatric psychiatric unit. The purpose of this study is to identify the experience of personal clothing restrictions for patients treated on the inpatient psychiatric unit, and to understand staff attitudes, awareness, and perceptions of the current clothing policy. You were selected as a possible participant in this study because you provide patient care on the inpatient psychiatric unit at the study site.

If you decide to participate, please complete the following survey. Your participation in this study is voluntary. Your completion of this survey indicates your consent to participate in this research study. The survey is designed to understand staff attitudes, awareness, and perceptions of the current clothing policy. This is a 25-item survey and it will take between 5-10 minutes to complete. You will be asked to answer demographic questions as well as questions about your attitude, awareness, and perception about the current patient clothing policy on the inpatient psychiatric unit at this facility. No benefits accrue to you for answering the survey, but your responses will be used to expand knowledge about the effects of personal clothing restrictions on staff in pediatric psychiatric units. Any discomfort or inconvenience to you derives only from the amount of time taken to complete the survey. Data will be collected using the Internet; while personally identifiable information will be collected for this survey, sociodemographic data will be collected and no guarantees can be made regarding the interception of data sent via the Internet by any third party. Data will be maintained to the degree permitted by the technology used. The information you provide will only be used for the

completion of this study and the use of this data will expire on the completion of the study or June 1st, 2020, whichever is sooner.

Your employer will not know whether or not you choose to participate in the study. Your decision whether or not to participate will not affect your future relationships with the University or the hospital. If you decide to participate, you are free to stop at any time without prejudice.

Please feel free to ask questions regarding this study. You may contact me if you have additional questions.

Thank you for your time.

Sincerely,

Scott C. Schmidt

Georgetown University DNP Student

By clicking the link below, I confirm that I have read this form and decided that I will participate in the study described above. Its general purposes, the particulars of involvement, and possible risks and inconveniences have been explained to my satisfaction. I understand that I can discontinue participation at any time. My consent also indicates that I am at least 18 years of age and that I provide direct patient care on the IPU part-time, full-time, as a moonlighter, or float staff. [Please feel free to print a copy of this consent form.]

- ○ I agree to participate
- ○ I decline

Section A: Sociodemographics

Q2.1 What is your age in years?

Slide to select your age ()	

Q2.3 Are you of Hispanic, Latino, or of Spanish origin?

- ○ Yes
- ○ No

Q2.2 What is your gender?

- ○ Male
- ○ Female
- ○ Other _____

Q2.4 How would you describe yourself?

- ○ White
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Native Hawaiian or Pacific Islander
- ○ Other _____

Q2.5 What is your highest level of education?

- ○ Less than high school
- ○ High school graduate
- ○ Some college
- ○ 2 year degree
- ○ 4 year degree
- ○ Professional degree
- ○ Doctorate

Q2.6 What is your current primary role?

- ○ RN (Registered Nurse)
- ○ BHC (Behavioral Health Clinician)
- ○ MHC (Mental Health Counselor)
- ○ Provider (NP, MD, DO)
- ○ Other _____

Skip To: Q2.8 If What is your current primary role? = RN (Registered Nurse)

Skip To: Q2.8 If What is your current primary role? = BHC (Behavioral Health Clinician)

Skip To: Q2.8 If What is your current primary role? = MHC (Mental Health Counselor)

Skip To: Q2.7 If What is your current primary role? = Other

Q2.7 What is your primary occupational responsibility at the Pediatric Mental Health Institute?

- ○ Inpatient
- ○ Outpatient
- ○ Research
- ○ Other _____

Q2.8 1. How many years have you been practicing as a health professional?

0 5 10 15 20 25 30 35 40 45 50

(Slide to select years) ()

Q2.9 How many total years have you been practicing in a pediatric setting?

0 5 10 15 20 25 30 35 40 45 50

(Slide to select years) ()

Q2.10 How long have you worked at Hospital XX?

0 5 10 15 20 25 30 35 40 45 50

(Slide to select years) ()

Q2.11 Have you previously worked in a **pediatric** setting before working at Hospital XX?

- ○ Yes
- ○ No

Skip To: Q2.13 If Have you previously worked in a pediatric setting before working at Hospital XX? = No

Q2.12 Which **pediatric** settings have you previously worked in before working at Hospital XX? (select all that apply)

- ○ Inpatient (non-mental health)
- ○ Inpatient Mental Health Setting
- ○ Outpatient (non-mental health)
- ○ Outpatient Mental Health Setting

Q2.13 Have you previously worked in an **inpatient psychiatric setting** where patients were mandated to wear hospital-issued clothing (e.g., scrubs) on admission?

- ○ Yes
- ○ No

Skip To: End of Block If Have you previously worked in an inpatient psychiatric setting where patients were mandated to we... = No

Q2.14 Select the patient populations where patients were mandated to wear hospital-issued clothing (e.g. scrubs) on admission.

- ○ Pediatric Psychiatric Population (2-18 years old)
- ○ Adult Psychiatric Population (18 years old or older)
- ○ Both pediatric and adult psychiatric populations

Section B: Attitudes and Awareness

"Currently all patients admitted to the inpatient psychiatric unit at Hospital XX have a restriction of their personal clothing and wear hospital-issued scrubs."

From this statement above, please select the option that best describes your belief for each of the following statements. There are not right or wrong answers. Your honest answers will best inform the study.

Q3.2 I have thought about the practice of patients having wearing hospital issued scrubs and having a restriction of their personal clothing.

	Never	Always
Slide cursor to record your response ()		

Q3.3 The practice of patients having a restriction of their personal clothing has been brought up by **patients** during their inpatient hospitalization.

	Never	Always
Slide cursor to record your response ()		

Q3.4 The practice of patients having a restriction of their personal clothing has been brought up by **family members** of patients during their inpatient hospitalization.

	Never	Always
Slide cursor to record your response ()		

Q3.5 I feel that the current clothing policy should change.

	Not at all	Absolutely
Slide cursor to record your response ()		

Q3.6 There are benefits to restricting a patient's clothing.

	Not at all	Absolutely
Slide cursor to record your response ()		

Q3.7 Would a change in the clothing restriction policy hinder the ability to provide quality care?

	Not at all	Absolutely
Slide cursor to record your response ()		

Q3.8 Do you think a policy should be implemented to allow patients to wear their own clothing on admission?

	Not at all	Absolutely
Slide cursor to record your response ()		

Q3.9 Do you anticipate legal problems with changing the current clothing policy to allow patients to wear their own clothing on admission?

	Not at all	Absolutely
Slide cursor to record your response ()		

Q3.10 Do you anticipate safety problems with changing the current clothing policy to allow patients to wear their own clothing on admission?

	Not at all	Absolutely
Slide cursor to record your response ()		

Q3.11 Have you had concerns about the current clothing policy before taking this survey?

	Not at all	Absolutely
Slide cursor to record your response ()		

Q3.12 Do you think patient/family satisfaction scores would be positively impacted if patients were permitted to wear their own clothing?

	Not at all	Absolutely
Slide cursor to record your response ()		

Q3.13 Do you think the current policy of clothing restriction upon admission should remain as it is now?

	Not at all	Absolutely
Slide cursor to record your response ()		

Q3.14 Are you aware of the Colorado statute regarding the wearing of personal clothing and patient rights surrounding this?

	Not at all	Absolutely
Slide cursor to record your response ()		

Q37 Comment (s): _____

Appendix B

Staff Comments from Self-Reported Questionnaire

- The questions are worded "practice of restricting..." Most all patients ask for their clothes back, but a lesser percentage di[s]cuss the practice of restricting. That made answering those questions a little difficult. I do not consider asking for personal clothes back a discussion about practice, for clarification.
- If patients are allowed to wear their own clothing upon admission, I would like some kind of restriction stating if unsafe the hospital will provide hospital issued scrubs for safety concerns.
- Scrubs allow all staff in hospital to recognize the safety risk of a newly admitted psychiatry patient. Raises extra awareness to all staff that the patient is new and may be higher risk for suicide, elopement, and /or aggression.
- Admitting patients in scrubs gives staff a better idea of who has just gotten to the unit, and may need extra attention. Scrubs are an also easy way to indicate who has demonstrated unsafe behaviors. I think the practice of the policy can sometimes be mishandled, such as putting a patient back into scrubs for whatever reason after having earned their clothing back. Clothing is not always searched well enough on admission to be completely sure the patient does not have anything on them which they could use in an unsafe manner.
- I hope that this survey will help with a change. Thank you for doing it!

- Your study did not discuss unlocked residential facilities. I think the main reason the current policy is an issue is providers waiting long after the client's acute crisis has been over. I see this primarily as a provider problem.
- Its a ni[c]e idea but it will be a safety issue. There will need to be a very well written and strictly enforced policy for patients who self harm on the unit. For example, SIB puts them back into scrubs for a minimum amount of time. And any attempts on the unit should be placed in scrubs their entire stay.
- Thank you for taking the time to complete this study!
- I feel like it is important to consider change in many policies after 2-5 years. The environment on a psych unit changes variably over time, based on the needs of the community, modality advancements and the reshaping of treatment teams.

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